

DISCOUNT MEDICAL PLAN ORGANIZATION

STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION

KNOW BY ALL MEN BY THESE PRESENTS, THAT "NAME OF DISCOUNT MEDICAL PLAN ORGANIZATION" AS PRINCIPAL, (hereinafter referred to as "the Principal"), and

AS SURETY, (hereinafter referred to as "the Surety"), are held and firmly bound unto DAVID ALTMAIER, Insurance Commissioner, and his successors in office, in the sum of THIRTY FIVE THOUSAND AND NO/100 (\$35,000) in lawful money of the United States, to the payment whereof we hereby bind ourselves, jointly and severally, and our successors, assigns, and representatives.

Signed and sealed this ____ day of _____, A.D. 2016.

THE CONDITION OF THE ABOVE OBLIGATION IS, THAT WHEREAS, by virtue of Chapter 636, Florida Statutes, Part II the above bounden, the Principal herein named, is required to make a deposit of Thirty Five Thousand and no/100 dollars (\$35,000) in cash or, to comply with s. 636.236, F.S., shall file with the said Insurance Commissioner a surety bond of a surety company authorized to do business in the State of Florida, said bond company and company to be approved of by said Insurance Commissioner and said bond to be held by the Insurance Commissioner to assure faithful performance of the Principal's obligations to all parties to discount medical plan organization contracts or other such documents as imposed by said Chapter 636, Part II, Florida Statutes, by said principal herein named, in the State of Florida while this bond is in effect;

AND WHEREAS, the above bounden, the Principal herein named, has elected to give such surety bond with the Surety above named;

NOW, THEREFORE, if the said Principal named here in shall faithfully perform its obligation to its members, and shall pay each, every and all of its liabilities to or on account of its members in the State of Florida after the said liabilities have been adjusted between the Principal and its members, in the mode prescribed by the contract between the Principal and its members, if a mode be prescribed, or a judgment, or order or decree of a Court having jurisdiction of the subject, and shall fully and faithfully respond to and settle all said obligations to or on account of its members arising from contracts effectuated while this bond is in effect and resting upon it by virtue of its said contracts with its members, or imposed upon it by laws of the State of Florida, then and in that event said bond shall be null and void.

IF IS FURTHER EXPRESSLY UNDERSTOOD AND AGREED BY AND BETWEEN THE PARTIES HERETO, THAT THIS BOND MAY NOT BE CANCELLED OR RELEASED UNTIL AFTER 60 DAYS NOTICE IN WRITING TO THE INSURANCE COMMISSIONER, and the discount medical plan organization insured under the bond shall, within 30 day of the filing of the Notice of Termination, provide the Office with a replacement bond, meeting the requirements of s. 636.236(1), Florida Statutes.

IT IS FURTHER EXPRESSLY UNDERSTOOD AND AGREED, that the cancellation of a bond does not relieve the obligation of the issuer of the bond for claims arising out of the contracts issued prior to the cancellation of the bond unless a replacement bond is secured. In no event shall the issuer's aggregate liability under the bond exceed the face amount of the bond.

IN WITNESS THEREOF, the said parties hereunto have caused to be set the hands of their respective proper officers and to be affixed their respective corporate seals this ____ day of _____, A.D. 2016.

Signed and sealed in the presence of:

Witness

Witness

By: _____
President

By: _____
Secretary

Executed at _____, Florida

This ____ day of _____, 2016

By: _____

NOTE: Attach to this Bond a properly certified copy of the Agent's Power of Attorney.

Bond forms change; this is for educational purposes only.

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM INSURANCE COVERAGE
ENDORSEMENT

Coverage for acts of terrorism as defined in S. 102(1) of the Terrorism Risk Insurance Act of 2002 (“the Act”) is already included in this surety bond. You should know that, effective November 26, 2002, under your existing coverage, any losses caused by certified acts of terrorism would be partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The portion of your annual premium that is attributable to coverage for acts of terrorism is \$0.

Bond forms change; this is for educational purposes only.

As your insurance/surety company we are sending you this notice to comply with the Terrorism Risk Insurance Act of 2002.

Surety Bond Application

AGENCY NAME: _____ AGENCY CONTACT: _____
 AGENCY PHONE: _____ AGENCY FAX: _____ AGENCY EMAIL: _____
 AGENCY ADDRESS: _____ City: _____ State: _____ Zip: _____

CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT? _____

NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND? _____

SECTION I: BOND APPLIED FOR

Type of Bond: _____ Effective Date: _____ Expiration Date: _____

Type of Company **CORP** **LLC** **DBA** **PARTNERSHIP** Bond Amount: _____

(Obligee): _____

Obligee Address _____

SECTION II: GENERAL INFORMATION

Applicant's Name: _____ Spouse Name: _____

SS#: _____ Spouse SS#: _____ Home Phone: () _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Business Name: _____

Business Phone: () _____ Business Fax: () _____ E-mail: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Date Business BEGAN under present Individual or Firm Name: _____ BUSINESS TAX ID: _____

HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES NO DO YOU HAVE ANY LIENS, CLAIMS OR JUDGMENTS AGAINST YOU? YES NO

HAS APPLICANT EVER FAILED IN BUSINESS? YES NO HAS APPLICANT EVER FILED BANKRUPTCY? YES NO

IF YES TO ANY, PLEASE EXPLAIN ON A SEPERATE SHEET OF PAPER

SECTION III: ADDITIONAL OWNERS OR PARTNERS AS REQUIRED

NAME: _____ SPOUSE NAME: _____

SS#: _____ SPOUSE SS#: _____ PHONE: _____

HOME ADDRESS: _____ City: _____ State: _____ Zip: _____

PERSONAL FINANCIALS (IF MORE THAN ONE OWNER, EACH HAS TO FILL OUT THIS APPLICATION)

STATEMENT OF ASSETS AND LIABILITIES AS OF

ASSETS		LIABILITIES	
CASH IN BANK		NOTES PAYABLE TO BANKS	
CASH ON HAND		NOTES TO OTHERS (excl. of equipment)	
STOCKS AND BONDS		ACCOUNTS PAYABLE	
ACCOUNTS RECEIVABLE		FEDERAL & STATE INCOME TAX DUE	
NOTES RECEIVABLE		ALL OTHER TAXES	
INVENTORY		ACCRUALS, PAYROLLS, ETC.	
CASH VALUE LIFE INSURANCE			
EQUIPMENT		DUE ON EQUIPMENT	
REAL ESTATE		DUE ON REAL ESTATE	
OTHER ASSETS		OTHER LIABILITIES	
		CAPITAL STOCK (if a corporation)	
		SURPLUS AND UNDIVIDED PROFITS	
TOTAL ASSETS		TOTAL LIABILITIES	
		NET WORTH	
Name of Owners	Name and Title of Officers	% OWNERSHIP IN COMPANY	

COMPLETION OF THIS FORM CONSTITUTES PERMISSION FOR WORLDWIDE INSURANCE SPECIALISTS INC. TO OBTAIN CONSUMER INFORMATION WHICH WILL BE USED TO DETERMINE BONDING ELIGIBILITY. THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE
 NO PREMIUM FINANCING WILL BE ACCEPTED AS PREMIUM IS EARNED IN FULL.

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